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Date: June 30, 2006 DSL-BQA-06-012

To: Nursing Homes NH - 08

From: Paul Peshek, Chief
Bureau of Quality Assurance, Resident Care Review Section

cc: Otis Woods, Director
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Immediate Jeopardy Citations

There has been an increase in the number of immediate jeopardy (IJ) citations in Wisconsin over the last two years: In 2005, the Bureau of Quality Assurance (BQA) issued 68 citations at the level of immediate jeopardy in long-term care facilities; thus far, in 2006, we have issued 35 immediate jeopardy citations. This compares to an average of 25 immediate jeopardy citations/year from 2000 – 2004. In this memo, I highlight the types of situations that are being cited at the level of immediate jeopardy. I encourage you to look at your facility's practices to ensure that these types of practices do not occur.

Immediate jeopardy occurs whenever noncompliance with a federal regulation:

- Has caused, or is likely to cause, serious injury, serious harm, serious impairment, or death to a resident; and
- Immediate corrective action is, or was, needed to prevent serious harm from occurring.

A facility must remove an immediate jeopardy within 23 days from the date of the exit conference or face termination from the Medicare and/or Medicaid program(s). Once a nursing home has identified the root cause(s) that led to noncompliance, and taken steps to remove the immediacy for serious harm, the nursing home must still correct the underlying systems problem(s) that led to the deficient practice. Nursing homes cited with immediate jeopardy are eligible for civil money penalties in the higher range of $3,050 to $10,000 for each day that immediate jeopardy exists.

The majority of immediate jeopardy citations in Wisconsin in 2005 and 2006 have fallen into the following nine categories:

- *Failure to appropriately supervise residents to reduce the risk for accidents (F324).* The majority of the immediate jeopardy citations at F324 have fallen into four subcategories. These are:

    1. Wandering. Staff did not respond to alarms, or after responding to an alarm, did not verify that no one had gotten outside. These situations may have been avoided had staff

responded promptly to the alarm, done a thorough check around the entire building after the alarm went off, and after finding no resident outside, checked to see if all residents identified as having wandering behavior were accounted for.

2. Falls. Residents experienced repeated falls. Staff did not assess or evaluate the circumstances of the falls and did not develop or implement individualized approaches to reduce the risk for further falls. In these situations, BQA did not cite immediate jeopardy because the residents fell. Rather, we cited immediate jeopardy because nurses were not assessing the falls, reacting to the number of falls, and working to identify what other approaches might be implemented to reduce the number of falls, given that the current approaches were not effective.
3. Choking. Staff did not supervise residents with a history of choking and stuffing food into their mouths. These residents were either not closely supervised during meals or when they were on the unit and could access food independently.
4. Side rails. Residents had rehearsal events in which they became entrapped in the side rail. Once aware that this could occur, staff did not respond appropriately to prevent a subsequent incident.

- *Failure to prevent the development of stage 4 and/or infected pressure ulcers (F314).* Immediate jeopardy citations at F314 occurred because facilities had canned approaches for preventing or treating pressure ulcers, and did not individualize care to each resident. In most cases, staff had determined that the residents were at high risk for developing pressure ulcers, but did not develop or implement proactive approaches to prevent breakdown. Further, once pressure ulcers developed, staff did not respond by developing approaches to prevent further deterioration, and did not monitor the condition of the pressure ulcers daily. In many instances, pressure ulcer care was seen as the responsibility of the wound care nurse and not something for which all staff were responsible.

  The Centers for Medicare and Medicaid Services has been issuing updated investigative protocols for selected regulations. These protocols include guidance related to deficiency categorization, i.e., determination of the level of severity. The increase in the number of immediate jeopardy citations at F314 (four so far in 2006 vs. one in 2005) is directly related to this guidance. According to this guidance, immediate jeopardy should be considered when a resident develops an avoidable, stage 4 pressure ulcer; shows deterioration or no improvement in a stage 4 pressure ulcer that was present on admission; develops an avoidable, stage 3 or stage 4 pressure ulcer with associated soft tissue or systemic infection; or develops an avoidable stage 3 or 4 pressure ulcers as a result of extensive failures in pressure ulcer care.

- *Inappropriate action following a significant condition change in a resident (F309).* The immediate jeopardy citations at F309 occurred for the following reasons:

  1. Choking. Staff did not clear the airway or perform the Heimlich maneuver for residents who slumped over while eating. Even for residents who are no-code, the standard of practice is to clear the airway if choking is suspected.
  2. Cardiopulmonary resuscitation. Staff could not quickly determine that a resident was full code and did not begin, or did not promptly begin, cardiopulmonary resuscitation. Facilities need to have a system whereby they can quickly identify who is full code or no code and respond immediately when cardiopulmonary resuscitation is indicated.
  3. Head injuries. Staff did not monitor, or did not closely monitor, neurological signs of residents who had fallen and hit their heads. When neurological signs began to

deteriorate, staff did not ensure RN assessment of the resident or promptly consult with the physician as needed.

4. Fluid restrictions. Staff did not monitor the fluid intake of residents whose physicians had placed them on restricted fluid intake.
5. Inappropriate response to hypoglycemia. Staff attempted to give oral glucose to residents who were unresponsive and unable to swallow, thereby compounding the situation by creating a risk for aspiration.
6. Medication errors. Staff gave residents wrong, high-risk medications or failed to give medications as ordered, e.g., Coumadin. Staff did not closely monitor the conditions of residents who had been given high-risk medications in error.

In all these cases, there was not a prompt RN assessment, and either no contact, or an untimely contact, with the physician. These situations may have been avoided had staff promptly notified the charge nurse of the condition change, or if licensed nurses had promptly assessed the resident when notified of the condition change, recognized the seriousness of the condition change, and taken appropriate follow-up action based on an accurate assessment.

- *Failure to follow professional standards of practice (F281).* F281 is a process regulation that specifies a manner in which care shall be given. In general, citations of process regulations have increased since we received direction from the Centers for Medicare and Medicaid Services March 2005 (S&C 05-20) to cite all independent, but associated, deficient practices (in other words, all processes that led to deficient practices in Quality of Care, Quality of Life, etc.). Generally, we cited F281 because of a failure to develop, or to follow, professional standards of practice; which led to a serious outcome, or a potential serious outcome, at a quality of care or quality of life regulation. Immediate jeopardy citations at F281 most often involved:

  1. LPNs practicing outside the scope of their practice. N6, Nurse Practice Act, at N 6.04(1) defines standards of practice for licensed practical nurses.
     "In the performance of acts in basic patient situations, the L.P.N. shall, under the general supervision of an R.N. or the direction of a physician, podiatrist, dentist or optometrist...:
     (b) Provide basic nursing care; [which is defined at N 6.02 as care that can be performed following a defined nursing procedure with minimal modification, in which the responses of the patient to the nursing care are predictable].
     (c) Record nursing care given and report to the appropriate person changes in the condition of a patient."
     LPNs do not have the training to assess condition changes and must report resident condition changes to the appropriate person.
  2. Registered nurses (RNs) failing to assess residents or to report significant changes in residents' conditions to the physician, as required at N6, Nurse Practice Act.
  3. Failure to have professional standards of practice in relation to the treatment of pressure ulcers, treatment of hypoglycemia, cardiac pain, serious burns, etc.

  These citations may have been avoided had LPNs promptly notified the charge registered nurse of resident condition changes, or if registered nurses had promptly assessed the resident when notified of the condition change, recognized the seriousness of the condition change, and taken appropriate follow-up action based on an accurate assessment.

- *Resident-to-resident abuse (F224).* These citations involved residents who were aggressive, unpredictable, fast, and impulsive; and who had a pattern of physically or sexually assaulting

other residents. We did not cite immediate jeopardy because the facility had admitted these individuals, or because they occasionally acted out, but because the residents were volatile and unpredictable and the facility had not appropriately managed their behaviors. Instead of proactively working to prevent abuse from occurring in the first place, facility staff relied on redirecting the aggressive resident or separating the resident after an aggressive act had been committed. These citations may have been avoided had staff assessed the time, place, and triggers of each incident, proactively developed and implemented approaches to modify the environment (which may have necessitated a psychiatric consult); and/or more closely supervised the potentially aggressive resident to help reduce the number of opportunities for resident-to-resident altercations.

- *Failure to promptly consult with the physician following a significant change in condition (F157).* These immediate jeopardy citations involved incidents where residents had significant changes in their physical conditions. These included changes in neurological signs following a head injury, signs of gastrointestinal bleeding in residents on anticoagulant therapy, worsening of a pressure ulcer in terms of size or odor, and chest pain. In all these cases, there was either no contact, an untimely contact with the physician, or a fax sent to the physician's office at a time when the office was closed. The federal regulation requires the facility to "consult with" the physician, not to "notify" the physician. These citations may have been avoided had the facilities developed clear guidelines on what constituted a significant change in condition (for example, as defined by the Association of Medical Directors), had clear policies that the expectation was to promptly "consult with" the physician when faced with a significant change, and consistently implemented these policies. This would include making sure that nurses knew what to do when they were unable to reach the attending physician.

- *Failure to protect residents while smoking (F328).* These immediate jeopardy citations involved residents who were allowed to smoke while their oxygen tank was running or while the tank was still attached to their wheelchair. There is an oxygen-enriched environment, both around the oxygen tank because of the venting that occurs, and around the nasal cannula. An oxygen-enriched environment makes the air highly combustible and makes burning more efficient. A spark from a match, a lighter, or a cigarette, could cause lit materials to combust and burn more vigorously. This could have caused serious burns to the resident, including burns to the resident's throat and lungs. These citations may have been avoided by more closely supervising the residents to ensure that their oxygen tank was turned off and removed to a distance of 6-10 feet from the wheelchair before allowing the residents to go outside to smoke.

- *Failure to protect residents from staff abuse (F223) or failing to immediately and thoroughly investigate allegations of serious abuse (F225).* The most serious abuse citations occurred on units that were infrequently, and predictably, supervised. Charge nurses generally came to these units on a predictable schedule (such as every two hours). Certain staff on these units took advantage of this schedule and used the periods of non-supervision to abuse residents, which included rape. Although these staff had been properly screened and trained in resident rights, the schedule of supervision created an environment in which abuse could occur. These citations may have been avoided with closer supervision of the unit and with a less predictable timetable for supervisory presence on the unit.

  Immediate jeopardy citations at F225 involved supervisory failure to immediately and thoroughly investigate allegations of abuse or repeated allegations of abuse. In these instances, nursing assistants and/or nurses reported allegations of abuse and sexual misconduct to the appropriate

manager/supervisor, who then failed to investigate the allegations of abuse. Failure to investigate the allegations, and the failure to keep residents safe while the investigation was being conducted, created opportunities for further abuse to occur. These citations may have been avoided had management immediately and thoroughly investigated the allegations of abuse and put measures in place, e.g., employee suspension or closer supervision whenever an outside person came to visit, to ensure the safety of residents while the investigation was being conducted.

- *Failure to immediately report critical lab values to the physician (F505).* In these situations, staff received lab reports with critical values. Staff either did not recognize the seriousness of the lab value, did not know the system for ensuring that this information got passed on, or did not know what to do when they were unable to reach the physician. These citations may have been avoided had the facilities had specific procedures and guidelines for handling and reporting critical lab values, including procedures on what to do if the physician was not available.

The above areas of concerns address the majority, but not all, of the immediate jeopardy citations that BQA has issued in the last 1½ years. I am making this information available so that you and your Quality Assessment and Assurance Committee can review your facility's policies, procedures, and standards of practice in these critical areas, and identify areas that may need strengthening, so that you can avoid citations in these areas. Please review this information with your QAA Committee to ensure that facility practices in these areas adequately protect residents.

If you have questions, please contact your Regional Field Operations Director at the location and phone number below.

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